

**TO HOSPITAL**  The hospital or attending physician may be retained.  
**TO FUNERAL DIRECTOR**  After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1974 CERTIFICATE OF DEATH

02603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Hampshire</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>Several Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Winchester</b>		d. STREET ADDRESS <b>45 Mechanic St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Annes</b>						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Geneva</b>	Middle <b>Caroline</b>		4. DATE OF DEATH <b>February 1</b>	Month <b>February</b>	Day <b>1</b>	Year <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1876</b>	9. AGE (In years last birthday) yrs. <b>81</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Frank Hildreth</b>		14. MOTHER'S MAIDEN NAME <b>Ripley</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b>		1 day						
DUE TO <b>Coronary Thrombosis</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Pneumonia</b>		1 week						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>994.9 Fracture of right clavicle and severe fall</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chestertown, Md.</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>1/18</b> , 19 <b>58</b> to <b>2/1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/1/58</b> , 19 <b>58</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert W. Farr</i>		ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED						
PHYSICIAN'S NAME (Type) <b>ROBERT. W. FARR</b>								
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Evergreen Cem.</b>		22d. LOCATION (City, town, or county) <b>Winchester</b>		
						State <b>New Hampshire</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 5 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Reuben</i>		

## STATE OF MARYLAND CERTIFICATE OF DEATH

DEATH

MURKIN

BUREAU V. S

FEB 5 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## : 2075 CERTIFICATE OF DEATH

02064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 333 Cannon St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
3. NAME OF DECEASED (Type or print) First Mary		Middle C.	Last Chambers
4. DATE OF DEATH Feb. 6, 1958		Month Feb.	Day 6
5. SEX female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 4, 1889		9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Perry Dudley		14. MOTHER'S MAIDEN NAME Arminthia Darkus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-07-6523	17. INFORMANT x George Chambers
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Widespread Metastasis in Carcinoma of Pancreas INTERVAL BETWEEN ONSET AND DEATH 3 months 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 5, 1958, to Feb. 6, 1958, that I last saw the deceased alive on Feb. 6, 1958, and that death occurred at 3 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Feb. 6, 1958	
ACTUAL SIGNATURE Thomas J. Solon		PHYSICIAN'S NAME (Type) Thomas J. Solon Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Fairlee (col. Cem.)
22d. LOCATION (City, town, or county) near Chestertown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		24a. REC'D BY REGISTRAR DATE FEB 10 '58	24b. REGISTRAR'S SIGNATURE DeLoach

TO HOSPITAL  
may be referred to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

## CERTIFICATES OF DEATH

**RECEIVED**  
BUREAU V. S.  
FEB 10 1958

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2076 CERTIFICATE OF DEATH

02065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 37		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Sarah		First	Middle	Last	4. DATE OF DEATH February 27 1958	Month	Day	Year
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1872	9. AGE (In years lost birthday) yrs. 85	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Music Teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME J. Frank Coppage		14. MOTHER'S MAIDEN NAME Eliza Jane McFadden						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Fred Seney--Chestertown, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH 4 years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Vascular Disease		DUE TO						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED White	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from		March	19 54	to	Feb. 27	19 58	that I last saw the deceased alive on	
alive on		Feb. 27	19 58	and that death occurred at	2 P. M.	from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Robert W. Farry M. D.				M.D. Chestertown, Md.		DATE SIGNED 3/1/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 2		22c. NAME OF CEMETERY OR CREMATORIAL Church Hill		22d. LOCATION (City, town, or county) Church Hill, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Maryland		24a. REC'D BY REGISTRAR DATE MAR 5 '58		24b. REGISTRAR'S SIGNATURE Debel		

TO HOSPITAL  
may be referred to the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AR 5 1953

1953

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2077 CERTIFICATE OF DEATH

102066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. LENGTH OF STAY IN lb <b>10 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT &amp; QUEEN ANNE'S Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 CHESTERTOWN</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE BROWN</b>		First <b>GEORGE</b>	Middle <b>BROWN</b>
4. DATE OF DEATH <b>FEB 26 1958</b>		Last <b>FARR</b>	Month Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-31-85</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.E.T.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN FARR</b>	
14. MOTHER'S MAIDEN NAME <b>HARRIET CHANDLER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>	
16. SOCIAL SECURITY NO. <b>214-28-3758</b>		17. INFORMANT <b>Hosp. Chart</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>MESENTERIC THROMBOSIS</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-23, 1958</b> , to <b>2-26, 1958</b> , that I last saw the deceased alive on <b>2-25, 1958</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. T. KEEFE</i>		ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>	
DATE SIGNED <b>2-26-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 28, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Chester Cem.</b>
22d. LOCATION (City, town, or county) <b>Chestertown, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		24a. REC'D BY REGISTRAR DATE <b>FEB 28 1958</b>	24b. REGISTRAR'S SIGNATURE <i>Deb. Smith</i>

TO HOSPITAL OR  
TO FUNERAL  
HOME: After this certificate has been signed by the attending physician and completely filled in  
may be retained by the hospital or attending physician.  
Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1963 28 FEB

RECEIVED

TO HOSPITAL  
may be referred to as hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2078 CERTIFICATE OF DEATH

Reg. Dist. No. 02067

1. PLACE OF DEATH a. COUNTY <i>Kent</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kent + Queen Anne's Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Fawn</i>	Middle <i>Ruth</i>	4. DATE OF DEATH <i>Feb. 19- 1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-9-1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Gilbert Farrow</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy Harrington</i>	12. CITIZEN OF WHAT COUNTRY? <i>Address</i> <i>Mr. Gilbert Farrow. Chestertown MD</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>773.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Wgt on Birth about 11b 9oz</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/9</i> , 1958, to <i>Feb. 19</i> , 1958, that I last saw the deceased alive on <i>Feb. 19</i> , 1958, and that death occurred at <i>10A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Thomas J. Soden</i> M.D. ADDRESS (Street, city or town, state) <i>Chestertown, MD</i> DATE SIGNED <i>2/19/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>2-21-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Bonelli Chapel</i>	22d. LOCATION (City, town, or county) <i>Frederick - Md.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Millard Cooper, Hgtm. Dir.</i>		ADDRESS <i>2072353xv</i>	24a. REC'D BY REGISTRAR <i>Feb 24 '58</i>
		24b. REGISTRAR'S SIGNATURE <i>Dee Smith</i>	

## STATE CERTIFICATE OF DEATH

BUREAU W. M. F.  
RECEIVED  
FEB 24 1959

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2087 CERTIFICATE OF DEATH

02068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Worton		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Worton	
3. NAME OF DECEASED (Type or print) Sylvester		First	Middle
4. DATE OF DEATH February 27	Month	Day	Year 19 58
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 1875
9. AGE (In years last birthday) 82	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Graves		14. MOTHER'S MAIDEN NAME Edith Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Charles Graves		Address Worton, R.F.D. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic vascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- } (b) lying cause lost. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Coronary occlusion YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 1956, to <u>Feb. 27</u> , 1958, that I last saw the deceased alive on <u>2/27</u> , 1958, and that death occurred at <u>9:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D. DATE SIGNED <u>2/27/58</u>			
PHYSICIAN'S NAME (Type) Robert W. Farr		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/58	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery
22d. LOCATION (City, town, or county) Still Pond		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Alleson</u>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2088 Item 4 FilmG226 3-10-58 et

Reg. Dist. No.

02069

1. PLACE OF DEATH a. COUNTY <b>KENT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLINGTON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>KENT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X MILLINGTON</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First <b>MARTHA</b>	Middle <b></b>	Last <b>HARRIS</b>	4. DATE OF DEATH <b>FEB.</b>	Month	Day <b>23</b>	Year <b>1958</b>
5. SEX <b>F.</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 14, 1873</b>	9. AGE (In years lost birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>RICHARD ROBINSON</b>		14. MOTHER'S MAIDEN NAME <b>TEMPE COTTON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>THEODORE HARRIS.</b> 17. INFORMANT <b>MILLINGTON, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Arthritis</b> DUE TO <b>Smoking</b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>10-15 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>						20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>No injury</b>		20d. INJURY OCCURRED While <b>Not while</b> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>MILLINGTON</b>		(County) <b>Md.</b> (State) <b>MD.</b>
21. I certify that I attended the deceased from <b>Sept. 5</b> , 1957, to <b>Feb. 23</b> , 1958, that I last saw the deceased alive on <b>Feb. 22</b> , 1958, and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>MILLINGTON, MD.</b>		DATE SIGNED <b>2/26/58</b>
ACTUAL SIGNATURE <b>H.H. Hamilton</b>								
PHYSICIAN'S NAME (Type) <b></b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/29/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>SOUZA CHAPEL CEM.</b>		22d. LOCATION (City, town, or county) <b>CHESTERTOWN, RURAL MD.</b>		(State) <b>MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Millington, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Debrauch</b>		24b. REGISTRAR'S SIGNATURE		
				DATE <b>MAR 3 '58</b>				

СІДІВОМІСІАЛІСТИЧНА РОДНОВІРСКА ВІДОВА СІДІВОМІСІАЛІСТИЧНА

855

DECEMBER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2089

## CERTIFICATE OF DEATH

Reg. Dist. No. 02070

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Lost		4. DATE OF DEATH Month Day Year	
Walter Jewell Hepbron		February 11 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1900
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner	11. KIND OF BUSINESS OR INDUSTRY Farm
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry H. Hepbron	14. MOTHER'S MAIDEN NAME Larry Jewell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-30-7144	17. INFORMANT Mr. Percy Hepbron--Rock Hall, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO <i>Cerebral Aclusion</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>Hypertension</i> <i>Unknown</i> (c) <i>Atherosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 9</i> , 1958, to <i>Feb 11</i> , 1958, that I last saw the deceased alive on <i>Feb 11</i> , 1958, and that death occurred at <i>6 P</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Rock Hall, Md.</i> DATE SIGNED	
ACTUAL SIGNATURE <i>Robert A. Kitch</i>	M.D.		
PHYSICIAN'S NAME (Type) <i>NORBERT C. KITSCH.</i>	<i>Rock Hall, Md.</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Feb. 14</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL <i>Wesley Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Rock Hall, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elgar L. Lane</i>		ADDRESS <i>Church Hill, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>FEB 18 '58</i>
			24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>

TO HOSPITAL may be referred to hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGISTRATION NO.	1234567890	NAME OF DECEASED	JOHN D. BROWN
SEX	MALE	AGE	65
DEATH DATE	1958-02-18	TIME	10:00 AM
DEATH PLACE	HOME	CAUSE OF DEATH	HEART DISEASE
DEATH CERTIFIED	DOCTOR	DOCTOR'S SIGNATURE	DR. J. H. SMITH
REGISTRATION DATE	1958-02-18	REGISTRATION NUMBER	1234567890
BUREAU V. S.			
FEB 18 1958			
RECEIVED			

TO HOSPITAL  
may be referred to as hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2079 CERTIFICATE OF DEATH

Reg. Dist. No.

02071

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b I day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X near - Rock Hall,	
3. NAME OF DECEASED (Type or print)		First Joshua	Middle David
4. DATE OF DEATH		Month Feb. 10, 1958	Day 19
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1942
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Laurence Hopkins		14. MOTHER'S MAIDEN NAME Minnie Sisco	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no	17. INFORMANT Laurence Hopkins Rock Hall, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		Chronic Since Birth	
DUE TO (c)		Since Birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I attended the deceased from 2/10, 1958, to 2/10, 1958, that I last saw the deceased alive on 2/10, 1958, and that death occurred at 4:10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chestertown, Maryland	
ACTUAL SIGNATURE Thomas J. Salom	DATE SIGNED 2/10/58		
PHYSICIAN'S NAME (Type) Thomas J. Salom, M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF Feb. 14, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Sharptown (Col.)		22d. LOCATION (City, town, or county) Rock Hall, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Weller	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR FEB 13 '58	24b. REGISTRAR'S SIGNATURE Audrey

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2080 CERTIFICATE OF DEATH

Reg. Dist. No.

02072

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 5 years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						d. STREET ADDRESS Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First William	Middle A.	Lost Hudson	4. DATE OF DEATH Feb. 6, 1958	Month Feb.	Day 6	Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1893		9. AGE (In years (at birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Life Insurance		10b. KIND OF BUSINESS OR INDUSTRY Agent	11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME John Hudson		14. MOTHER'S MAIDEN NAME unk		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input type="checkbox"/> unknown) WW I		16. SOCIAL SECURITY NO. WW I	17. INFORMANT Mrs. Clifton Faulkner	Address Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH about 12 hrs			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probably Coronary Thrombosis or disturbed</u>		DUE TO <u>conduction</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <u>Coronary Sclerosis</u>						don't know			
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac dilatation and congestive heart failure</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.		(County)		(State)	
21. I certify that I attended the deceased from <u>Jan. 3, 1958</u> , to <u>Feb. 6, 1958</u> , that I last saw the deceased alive on <u>Feb. 6, 1958</u> , and that death occurred <u>9 P.M.</u> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED Feb. 7, 1958	
ACTUAL SIGNATURE <u>Robert W. Farr</u>											
PHYSICIAN'S NAME (Type) Robert W. Farr											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Hollywood Cem.		22d. LOCATION (City, town, or county) Harrington, Delaware		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR FEB 10 '58		24b. REGISTRAR'S SIGNATURE <u>As. esuch</u>					

TO HOSPITAL  
may be referred to hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. 4

VS A15 (4)  
15M 9/55

## CERTIFICATE OF DEATH

MARCH 10, 1959

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RECEIVED  
FEB 10 1959

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02073

Reg. Dist. No.

**TO DEPUTY** *1*: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Item 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		2. 2090		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Kent MARYLAND		b. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Chestertown - rural		plus 3 years		X Chestertown - rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First James	Middle Henry	Last Johnson	4. DATE OF DEATH Month 2 Day 17 Year 1955
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? ?	9. AGE (in years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) before		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA -					
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 213-24-1246		17. INFORMANT Jane Teller Address RFD 1 Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>but</i> Unknown, probable stroke or heart attack don't know 334x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>We</i> , Deceased had a stroke about 2 yrs ago. He was apparently and ate supper 2/16/58 & went up to bed. He was found dead 1:00A.M. the next day.				INTERVAL BETWEEN ONSET AND DEATH y	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemiplegia - 2 years				19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <i>Robert W. Farr</i>				DATE SIGNED 2/20/58	
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/58		22c. NAME OF CEMETERY OR CREMATORIUM Morgue (Col.) Cem. 22d. LOCATION (City, town, or county) Near - Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Willis Wells</i>		ADDRESS Chestertown, Md.		24a. REG'D BY REGISTRAR DATE FEB 25 '58	
				24b. REGISTRAR'S SIGNATURE <i>John E. Lewis</i>	

RECEIVED  
BUREAU V. S

FEB 25 1958

EXAMINER'S CERTIFICATE OF DEATH	
SEARCHED	INDEXED
SERIALIZED	FILED
FEB 25 1958	
FEDERAL BUREAU OF INVESTIGATION	
U. S. DEPARTMENT OF JUSTICE	

**TO HOSPITAL!** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2981 CERTIFICATE OF DEATH

02074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		d. STREET ADDRESS <b>Kent &amp; Calvert St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Calvert St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Harry</b>		First <b>Elmer</b>	Middle <b>Johnson</b>	Last <b>Johnson</b>	4. DATE OF DEATH <b>Feb. 17 1958</b>	Month <b>Feb.</b>	Day <b>17</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1869</b>		9. AGE (In years last birthday) <b>88</b> yrs.	10. IF UNDER 1 YEAR Months <b>88</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenant</b>		11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Jacob Johnson</b>			14. MOTHER'S MAIDEN NAME <b>Hannah Marjarum</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>I6I-I4-8623</b>		17. INFORMANT <b>Horace Johnson</b>		Address <b>Chestertown Kent &amp; Calvert Sts.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>coronary insufficiency</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b>		
(b) DUE TO <b>arteriosclerosis</b>						YEARS <b>4 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Prostate obstruction</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chestertown, Md.</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Feb. 27 1957</b> to <b>Feb 16 1958</b> , that I last saw the deceased alive on <b>Feb 17 1958</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>		DATE SIGNED
ACTUAL SIGNATURE <b>Thomas J. Solon</b>		M.D.						
PHYSICIAN'S NAME (Type) <b>Thomas J. Solon</b>		Chester County, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Wm. Penn Cem.</b>		22d. LOCATION (City, town, or county) <b>Somerton, Penna.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Beach</b>		

87 ДРОМПЛАВ-ЕНДЗАН-ЧО ТИМПРАДО-СТАТ-СИА-ЧИАМ

**BURIAU V. A.**

FEb 20 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2091

## CERTIFICATE OF DEATH

Reg. Dist. No.

02075

1. PLACE OF DEATH a. COUNTY		Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Md.		b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington Rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Feb.	Month	Day	Year		
Mary			Kantor		Sept. 24, 1895	27	Feb.	27	1895		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Female	White			Sept. 24, 1895	62 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Tony Matches				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mary Reed		1531 Bush St. Address Baltimore Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Aphoplexy						one year.					
(c) DUE TO Hypertension						2					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE DR. GEZA KORALEWSKI		M.D.									
PHYSICIAN'S NAME (Type)		KORALEWSKI				MILLINGTON, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3, 1958		22c. NAME OF CEMETERY OR CREMATORIAL St. Dennis Cem.		22d. LOCATION (City, town, or county) Rural Galena Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Edward Miller		ADDRESS Millington Md.		24a. REC'D BY REGISTRAR DATE MAR 5 '58		24b. REGISTRAR'S SIGNATURE Red Smith					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

RECEIVED

RECEIVED

BUREAU V. S.

MAR 5 1963

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 02076

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown	
3. NAME OF DECEASED (Type or print) First Donald Middle Last Keen		4. DATE OF DEATH JUN 21 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		11. BIRTHPLACE (State or foreign country) Rockville Centre, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry T. Keen		14. MOTHER'S MAIDEN NAME Patricia Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT none Herman Blackway, Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
<p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b>  <b>929.8</b>          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Was out walking about 2:00P.M. 2/22/58 and was missed by late afternoon. Search was made. The body was found DUE TO under a hole in the ice on a branch of Lankford Bay. Death is presumed to have been caused by drowning.</b></p>			
INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Probably fell through a hole in the ice.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>afternoon 2/22 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Lankford Bay</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Chestertown</b>		20f. (City or town) (County) (State) <b>Kent, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		DATE SIGNED 2/24/58	
EXAMINER'S NAME (Type) <b>Robert W. Farr, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>near Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS <b>Chestertown, Md.</b>	
		24a. REC'D BY REGISTRAR <b>Feb 26 '58</b>	
		24b. REGISTRAR'S SIGNATURE <i>Deb. Wells</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

EDUCATIONAL LEADERSHIP IN THE STATE OF DEAN

BUREAU V. S.

EEB 26 1998

REGIY ED  
SEP 26 1983

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2082 CERTIFICATE OF DEATH

Reg. Dist. No. 02077

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be referred to the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		d. STREET ADDRESS Liberty		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMES		First OSCAR	Middle McGinnis	Lost 7	4. DATE OF DEATH Feb	Month 5	Day 19	Year 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1898		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas McGinnis				14. MOTHER'S MAIDEN NAME Ella Lee Startt				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-10-3704		17. INFORMANT Hospital Records, Chestertown, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 15 hours								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)		Coronary Sclerosis		Don't know		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 2/4/58, 19, to 2/5/58, 19, that I last saw the deceased alive on 2/5/58, 19, and that death occurred at 12550A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Feb 5, 1958								
ACTUAL SIGNATURE ROBERT W. FARR		M.D.						
PHYSICIAN'S NAME (Type)		ROBERT W. FARR						
22a. BURIAL CREMATION, REMOVAL (Specify) Feb. 8, 1958	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel		22d. LOCATION (City, town, or county) Rock Hall		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 11 '58		24b. REGISTRAR'S SIGNATURE Albert J. Smith		

## CERTIFICATE OF DEATH

BUREAU V. S

FEB 11 1963

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2083 CERTIFICATE OF DEATH

Reg. Dist. No. 020178

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestereto wn		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne's			d. STREET ADDRESS Fairlee		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Noble	Middle Walton	Last Middleton	4. DATE OF DEATH February 3	Month Year 19 58
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Maryland 12-6-23	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Noble H. Middleton			14. MOTHER'S MAIDEN NAME Ethel Perry		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II & Korean		16. SOCIAL SECURITY NO. 220-26-3378		17. INFORMANT Hospital records—Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 393.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			Staphlococcic meningitis Mastoiditis		
			INTERVAL BETWEEN ONSET AND DEATH 8 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-28-58, 19 to 2-3-58, 19, that I last saw the deceased alive on 2-3, 19 58, and that death occurred at 12:10a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 2-3-58					
ACTUAL SIGNATURE a.c. Dick					
PHYSICIAN'S NAME (Type) A.C. Dick		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Feb. 5, 1958		22c. NAME OF CEMETERY OR CREMATORIAL St. Paul Cem.		22d. LOCATION (City, town, or county) (State) near - Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells			ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE FEB 5 1958
					24b. REGISTRAR'S SIGNATURE A. L. Beach

## CERTIFICATE OF DEATH

BUREAU U. S.

FEB 5 1928

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2084 CERTIFICATE OF DEATH

Reg. Dist. No.

02079

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		d. STREET ADDRESS 17X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

72	3. NAME OF DECEASED (Type or print)	First Lelia	Middle	Last Paynter	4. DATE OF DEATH Feb. 28,	Month	Day	Year 1958
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 18. 1885	9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Fletcher Sparks	14. MOTHER'S MAIDEN NAME Mary Reese
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None	16. SOCIAL SECURITY NO.	17. INFORMANT John R. Sparks Box 78 New Castle Del.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (b) DUE TO (c)	Uremic Terminal Nephritis Pyelitis & cystitis -	INTERVAL BETWEEN ONSET AND DEATH 5wks ?
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
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20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from _____, 19_____, to Feb 28, 1958, that I last saw the deceased alive on Feb 28, 1958, and that death occurred at 10 AM, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED 3/1/58
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ACTUAL SIGNATURE Thomas J. Solon	PHYSICIAN'S NAME (Type) THOMAS J. SOLON	CHESTERTOWN MD.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/3/58	22c. NAME OF CEMETERY OR CREMATORIAL Sudlersville Cem.	22d. LOCATION (City, town, or county) Sudlersville Md. (State)
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23. FUNERAL DIRECTOR'S SIGNATURE Edward Willow	ADDRESS Mallington Md.	24a. REC'D BY REGISTRAR DATE MAR 5 '58	24b. REGISTRAR'S SIGNATURE DeLoach
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## CERTIFICATE OF DEATH

FBI - NEW YORK

BUREAU V. S.  
RECEIVED  
MAR 5 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2093 CERTIFICATE OF DEATH

02088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle A.	Last Schuman
4. DATE OF DEATH	Feb.	Month	Doy
	24		19 58
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1876
Male	White		9. AGE (In years lost birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobiles	11. BIRTHPLACE (State or foreign country) Maryland
		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles A. Schuman		14. MOTHER'S MAIDEN NAME Elizabeth Eckert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-28-8558	17. INFORMANT Charles H. Schuman Rock Hall, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 21</u> , 1958, to <u>Feb 24</u> , 1958, that I last saw the deceased alive on <u>Feb 21</u> , 1958, and that death occurred at <u>3 P.M.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>D. Kester</u>	M.D.	<u>Rock Hall</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Feb. 26	22b. DATE THEREOF Feb. 26	22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel	22d. LOCATION (City, town, or county) Rock Hall Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS Church Hill, Md.	24a. REC'D BY REGISTRAR DATE FEB 28 '58
		24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>	

TO HOSPITAL  
may be referred  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF

## CERTIFICATE OF DEATH

1513200

DEATH

C. H. F. B.

DEATH CERTIFICATE

Died on 10/20/1968

BUREAU OF

10/23/68 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit Permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2985 CERTIFICATE OF DEATH

Reg. Dist. No. 02081

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. LENGTH OF STAY IN lb x <b>R.D.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT QUEEN ANNE'S</b>		e. STREET ADDRESS <b>R.D.</b>	
3. NAME OF DECEASED (Type or print) <b>John W. Scott</b>		First <b>John</b>	Middle <b>W.</b>
4. DATE OF DEATH <b>2</b>	Month <b>2</b>	Day <b>17</b>	Year <b>1958</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEP. 9 1899</b>
		WIDOWED <input type="checkbox"/>	9. AGE (In years at birthday) <b>58</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at college</b>	11. BIRTHPLACE (State or foreign country) <b>U.S. MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>W.M. JOSEPH SCOTT</b>		14. MOTHER'S MAIDEN NAME <b>ADDIE BOULTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>217-16-9155</b>	17. INFORMANT <b>Mrs. Ada Scott (wife) Chestertown, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Cormary Thrombosis			
INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hours</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO None		(c) DUE TO None	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>None</b>	
20c. TIME OF INJURY Hour a. p.m. p.m.	Month <b>19</b>	Day <b>29</b>	Year <b>1958</b>
20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>		
21. I certify that I attended the deceased from <b>2-9-58</b> to <b>2-9-58</b> , that I last saw the deceased alive on <b>2-9-58</b> , and that death occurred at <b>3:05 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Manfred Gerstly</b> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <b>MANFRED J. GERSTLY</b> DATE SIGNED <b>211 CAMPUS AVE 2/9/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 11, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Wesley Chapel Cem.</b>	22d. LOCATION (City, town, or county) <b>Rock Hall, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>	ADDRESS <b>Chestertown, Md.</b>	24a. REC'D BY REGISTRAR <b>FEB 11 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred E. ...</b>

CERTIFICATE OF DEATH

BUREAU V. 5

FEB 11 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02082

2094

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		c. LENGTH OF STAY IN 1b 11 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kennedyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First MARY	Middle BELLE	Last SMITH	4. DATE OF DEATH February 22 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months Ds Ds Hours Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 29, 1872	85	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William E. Sparks			14. MOTHER'S MAIDEN NAME Sarah Augusta Sparks		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Mrs. Adda Bond, Kennedyville, Md. (daughter)	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH 7 hours		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO CORONARY ARTERIOSCLEROSIS			11-12 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 15, 1956, to February 22, 1958, that I last saw the deceased alive on February 22, 1958, and that death occurred at 11:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md.					
ACTUAL SIGNATURE ROBERT W. FARR, M.D.		DATE SIGNED February 22, 1958			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/57		22c. NAME OF CEMETERY OR CREMATORIAL Riverview Cemetery	
22d. LOCATION (City, town, or county) Wilmington Delaware					
23. FUNERAL DIRECTOR'S SIGNATURE Albert J. McCrory ADDRESS 2700 Washington St. Wilmington Delaware					
24a. REC'D BY REGISTRAR DATE FEB 25 '58			24b. REGISTRAR'S SIGNATURE Albert J. McCrory		

## CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
FEB 25 1958				
BUREAU X. S.				
FEB 25 1958				
RECEIVED				

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2-95

## CERTIFICATE OF DEATH

Reg. Dist. No.

02083

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETTERTON</b>		c. LENGTH OF STAY IN lb <b>33 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETTERTON</b>	
3. NAME OF DECEASED (Type or print) <b>SARAH</b>		First <b>ELLEN</b>	Middle <b>STONE</b>
4. DATE OF DEATH <b>FEB 28</b>		Last <b>1958</b>	Month <b>Day</b> Year <b>Year</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>MAY 14, 1866</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>HANLEY, ENGLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JESSE ASH</b>	
14. MOTHER'S MARRIED NAME <b>HANNAH TOFT</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>EARL STONE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>uremia</b>		Address <b>BETTERTON, MD</b>	
DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost. <b>{</b> (b) <b>generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
DUE TO <b>{</b> (c) <b>{</b>		<b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>{</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>WORTON</b> (County) <b>MD.</b> (State) <b>MD.</b>	
21. I certify that I attended the deceased from <b>MAY</b> , 19 <b>53</b> , to <b>FEB 28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 26</b> , 19 <b>58</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Florence Deninger Joyce</b>		ADDRESS (Street, city or town, state) <b>WORTON, MD.</b> DATE SIGNED <b>2/28/58</b>	
PHYSICIAN'S NAME (Type) <b>FLORENCE DENINGER JOYCE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/3/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>LOUEN PARK CEMT</b>		22d. LOCATION (City, town, or county) <b>BALTIMORE</b> (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		ADDRESS <b>STILL POND, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be referred to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

MEXICO CITY

MEXICO CITY

MEXICO CITY

NAME	AGE	SEX	DEATH DATE	DEATH PLACE
JOSE R. HOMÉ	60	MALE	3/13/33	MEXICO CITY
DEATH CERTIFICATE				
I, the undersigned, declare that the above information is true and correct.				
SIGNED: JOSE R. HOMÉ				
MEXICO CITY, MEXICO				

BUREAU V. S.  
3/13/33  
MEXICO CITY  
1933

RECEIVED  
3/13/33  
TOMAS VARGAS CEMETERY  
MEXICO CITY  
MEXICO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1986 CERTIFICATE OF DEATH

Reg. Dist. No.

02084

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb I day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton		d. STREET ADDRESS RFD Bigswod		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.				d. STREET ADDRESS RFD Bigswod		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Kevin	Middle Tiller	Last Tiller	4. DATE OF DEATH 2/14/58	Month Feb	Day 14	Year 1958
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Mar 10, 1957		9. AGE (In years last birthday) yrs. Month Mar	IF UNDER 1 YEAR Days 11	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Garven Potts		14. MOTHER'S MAIDEN NAME Edith Tiller						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. no		17. INFORMANT Edith Tiller Worton, Md. RFD		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia						INTERVAL BETWEEN ONSET AND DEATH 6 hours		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from 2/12, 1958, to 2/14, 1958, that I last saw the deceased alive on 2/14, 1958, and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland 2/14/58 DATE SIGNED 2/14/58								
ACTUAL SIGNATURE Thomas J. Solon		PHYSICIAN'S NAME (Type) Thomas J. Solon		M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/16/58		22c. NAME OF CEMETERY OR CREMATORIAL Fountain Cem.		22d. LOCATION (City, town, or county) near Chestertown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Katherine Waller		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR FEB 21 '58		24b. REGISTRAR'S SIGNATURE Dee C. Smith		
2072141XV5								

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE - BIRMINGHAM

CERTIFICATE OF DEATH

SEARCHED

2239

BUREAU  
FBI  
RECEIVED  
EB 21 1958

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02085

Reg. Dist. No.

2-96

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b life		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Kent		MARYLAND							
First David		Middle A.		Last Whiteley		4. DATE OF DEATH Feb. 22		Month Day Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 12, 1948	9. AGE (in years last birthday) 9 yrs.	10. IF UNDER 1YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent County		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Paul E. Whiteley		14. MOTHER'S MAIDEN NAME Flora M. Dickerson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Herman Blackway, Chestertown, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Drowning x DUE TO in the late afternoon. Search was made. The body was (b) found under a hole in the ice on a branch of Lankford DUE TO Bay. Death is presumed to have been caused by drowning (c)		Was out walking about 2:00P.M. 2/22/58 and was missed		INTERVAL BETWEEN ONSET AND DEATH Instantaneously			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Probably fell through a hole in the ice							
20c. TIME OF INJURY Hour a.m. 14 late afternoon		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Lankford Bay		20f. (City or town) Chestertown		(County) Kent	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Robert W. Farr, M. D.						DATE SIGNED 2/24, 1958			
EXAMINER'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Chester Cem.		22d. LOCATION (City, town, or county) Chestertown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR FEB 26 1958		24b. REGISTRAR'S SIGNATURE Albert Leach			
				DATE					

A rectangular stamp with a decorative border. The word "RECEIVED" is printed in large, bold, capital letters at the top. In the center, it says "FEB 26 1893". To the left, it says "BUREAU V. S." (Bureau of Statistics).

1953 29 FEB